Long-Term Care

Universality Withering Away in a Nordic Welfare State?

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Published in:
Politiche Sociali

DOI:
10.7389/89913

Publication date:
2018

Document Version
Peer reviewed version

Citation for published version (APA):
Greve, B. (2018). Long-Term Care: Universality Withering Away in a Nordic Welfare State? *Politiche Sociali*, *5*(1), 15-28. https://doi.org/10.7389/89913

Long-term care – universality withering away in a Nordic welfare state?[i]

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Abstract

Most welfare states are seeing a greying of the population as people are living longer, and also as a consequence of fertility rates having been relatively low for some time. It has been argued that this causes a strong pressure on the economic sustainability of the welfare states, while at the same time also opens the way for the risk that the elderly in need of care do not get the necessary care.

This economic and care pressure has caused a search for new options and possibilities in the delivery of long-term care in Nordic countries. This includes strategies of rehabilitation and re-enablement of the elderly, and also the use of welfare technology as a way of overcoming the pressure, while at the same time helping the elderly to be able to stay as long as possible "in their own life". This is in line with international development where the elderly prefer to remain in their own home (Aspinal et. al. 2016), or as also labelled, "to age in place", as this enables them to have connections, familiarity and security (Wiles et. al. 2011).

However, despite the fact that many of these instruments are a positive way of supporting the elderly, their use has raised new issues of loneliness. This is because the increase in life-expectancy brings with it a higher risk when becoming old of having fewer family members and friends, and this combined with less mobility increases the risk of being lonely.

A concurrent challenge comes from the impact of the variety of service for the elderly, given local variations in Denmark, including the increasing use of private providers in part of the service for the elderly. This variation might imply a reduced universality of service provision in the Danish service welfare state.

Key-words: Long-term care, welfare technology, re-enablement, universalism, Nordic welfare states

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Introduction

There has, for a long time, been a debate on the possible impact of the ageing of the population (for an early discussion, see Greve 2006). There are constantly projections on the development in spending on state pension especially, but also on expenditures on services (see Gough 2011). Many countries have over the last 15–20 years changed their pension system towards a higher degree of defined contribution instead of defined benefit (Hinrichs 2018), but they have to a lesser extent changed and developed the long-term care systems to ensure support for an increasing number of elderly, so that they still rely heavily on family-based and informal networks.

This possible economic pressure is higher in the Nordic welfare states where state spending on long-term care is higher than in most of Europe. In these countries there are further tendencies towards marketization of care and re-enablement, while at the same time the role of civil society is very important (Greve ed. 2017). The aim of re-enablement is to enable people to carry out, especially, daily activities they themselves were previously able to do. How strong the impact is naturally depends on how healthy the elderly person is. Further, not only are people becoming on average older, but they also have an increasing number of healthy life years. Because of these trends, there is at the same time pressure on informal care in Denmark as well as in other countries (Groenou and Boer 2016), especially for women aged 50–59 (Verbaekel et. al. 2017).

This article will discuss these issues in relation to population aging in a universal welfare state, e.g. Denmark. During the course of the article four central, but interrelated questions will be answered:

1) How has rehabilitation and re-enablement developed in Denmark?
2) Is welfare technology used more now than previously?
3) What is the consequence of questions 1 and 2 on well-being of the elderly?
4) Is there equality in access to services within a decentral welfare state?

The article will only focus on long-term care for the elderly, e.g. not including people with disabilities in need of long-term care.

The Long-term care system in Denmark: a short description

Long-term care in Denmark is based upon central rules. However, the actual delivery and decisions lie within the municipalities, which finance their activities based upon a block grant from the state and the option to collect income and land tax locally (within an overall framework agreed with the state). Long-term care can be provided either in homes for the elderly or in private homes, with the aim of the policy for the elderly being – not, as historically, to stay as long as possible in one's own home – to stay as long as possible in one's own life. This is in line with the international development of aging in place, where the elderly can stay "as close as possible to a service user's own home and community" (Deusdad et. al. 2016, 148).

The overall development in spending has been based upon the elderly being seen as deserving, as is the case in most European countries (Taylor-Gooby 2017), and therefore retrenchment has, at least as a direct policy, been less prominent in this field. On several occasions in relation to the state finance bill, more money has been set aside for local welfare for the elderly. However, it is not always clear whether this extra money de facto increases the overall service level or whether municipalities just use these often more specific targeted money, instead of what they used to do, implying that no real increase in spending takes place.

Table 1 shows the development for people on old-age pension. This is a good indicator of the potential number of people in need of care, especially when looking at the group of those above the age of 80.

Table 1. Development for people receiving old-age pension 2007–2017

	2007	**2009**	**2011**	**2013**	**2015**	**2017**
Age						
65–80	621892	657929	720001	782811	827440	860278
80	229252	225782	233427	238889	247540	258835

Source: www.dst.dk/PEN11, accessed 10 August 2017.

Table 1 shows an increase of those above the age of 80 of close to 13%. If the elderly should be able to have the same support and abilities as previously, then this should in principle also imply an increase in the spending on, and size of, delivered long-term care. However, as Table 2 on delivered home care shows, this is not the case[1].

Table 2. Delivered home care since 2011, hours per week

	2011	**2012**	**2013**	**2014**	**2015**	**2016**
Provided hours, total	436496	409979	392977	398317	398017	403854
Provided hours on personal care, total	345189	327703	318372	322568	324380	334426
Provided hours on necessary practical duties, total	91307	82276	74604	75749	73637	69426

Source: www.dst.dk/AED01, accessed 10 August 2017.

Despite the increase in the number of elderly people, the provided hours have, especially for practical support in the private homes, been reduced. Despite this, those receiving support have continued on average to receive 0.7 hours per week for practical support, whereas for those getting personal care the average hours per week have increased from 4.6 to 5.0 hours per week[2]. Thus, it seems that those who actually get support continue at the same level, whereas the implication being that fewer elderly de facto get support.

This picture is confirmed in Table 3.

Table 3. Percentage of all individuals aged 67 and above receiving certain services

[1]The data do not go as far back as for Table 1, however, this is not a problem for the purpose of this article.
[2]This is based upon data from Denmarks Statistics, aed02 in statistikbank.

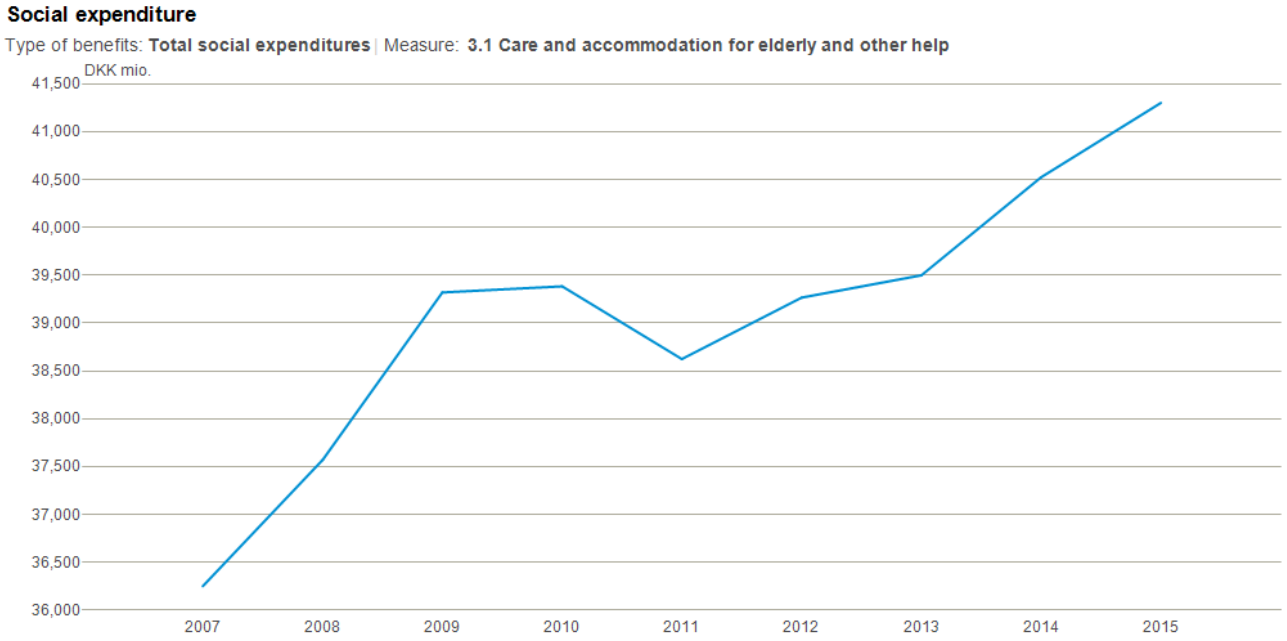
	2008	2009	2010	2011	2012	2013	2014	2015	2016
Permanent home care	..	..	..	16.5	15	13.7	13	12.5	12.2
Rehabilitation and maintenance rehabilitation (percentage of the population)	..	..	3.1	2.5	2.3	2.4	2.5	2.4	2.2
Preventative home visits	31.5	32.5	30.3	25.9	25.5	24.2	22.9	21.4	19.8

Source: www.statistikbanke.dk, aed21.

Table 3 shows that those receiving home care as well as rehabilitation (despite the later increased focus hereupon) have gone down since 2011, and the same for preventative home visits.

Figure 1 shows the overall development in spending on care.

Figure 1. Social expenditure of care and accommodation for elderly and other help



Source: www.statistikbanken.dk ESSPROS1, accessed 31 August 2017.

Figure 1 is in the actual year's prices still it shows that from 2009 to 2011 there was a decline in spending which then increased again from 2011 to 2015. However, given the increase in the number of elderly (see Table 1), this indicates that from 2007 to 2015 there has been a reduction in spending per person close to 10 percentage points. A core difficulty in knowing the impact hereof is that this can reflect that the elderly are healthier, the impact of rehabilitation and the use of welfare technology, but it might also imply that the elderly are receiving less service that they previously received.

Still, in general, Denmark fares well in international comparison with regard to public sector involvement in long-term care, as it has one of the highest levels of spending on long-term care in Europe (European Commission 2016, 322) at 2.4% of GDP in 2013. Denmark also fares well when looking at the active ageing index[ii] (see also Zaidi 2017), albeit with the exception of participating in society where it is ranked tenth (compared to second overall with Sweden in the top position) out of 28 countries in Europe. This includes

care to older adults, care to children and grandchildren and voluntary activities, indicating one weak spot in the Danish model.

Overall, the Danish approach, as within the classical depiction of the Nordic model, is universal, albeit the role of the family is still strong, and access to support (cleaning, cooking, shopping, etc.) in private homes is often not available if the person is living with a spouse/partner. This, most likely, also causes social inequalities, which typically arise with familization of care (Schmidt 2017).

A few methodological issues

The single case of the Danish welfare state approach to LTC can be considered as a more general depiction of the development in the universal Nordic welfare states within the specific field of long-term care.

Two core methodological issues in the field of long-term care are the following:

a) How are costs measured?
b) What is quality? (for references and discussions on this point, see Greve 2017).

How to measure costs is a problem as the boundary between health care and long-term care is not always clear and precise, and if there is no or at least insufficient long-term care, the elderly might be in hospitals, in what has been labeled “bed-blocking” (Gaughan et. al. 2015). The fact that delayed transfer from hospital to long-term care has an impact can be seen from different studies (Jasinarachchi 2009).

Quality is also difficult to measure, and could include issues such as effectiveness and care safety, patient-centeredness and responsiveness and care co-ordination (Donabedian 1985; OECD 2013). This article will not probe into this specific issue, albeit a few reflections related to loneliness will be included, in line with the patient-centeredness aspect of quality.

Even though the issue of the quality of care is important, so too is the question of data. This is less of a problem within a national study where more detailed data is available; and, further, for Denmark there are many studies related to the issues, especially on rehabilitation (Sundhedsstyrelsen 2017), which look into the impact of rehabilitation on users, workers and the economy. Thus, information is available to depict and extract knowledge on important aspects of the development.

Naturally, there are delimitations in such an article, and even though the elements used can be interpreted in the light of social investment, the article will not discuss this concept and the various approaches hereto (see instead Morel et. al. 2012; Midgley et. al. 2017). Social investment can be understood as “allocation of resources in ways that produce additional, future, value-added-resources. Social investment may be defined as allocations to social programs that produce returns and promote future social well-being” (Midgley et. al. 2017, 14). Naturally, many of the initiatives in long-term care in Denmark have had these aims.

There are also dividing lines between the health care and hospital sector, such as if insufficient long-term care is available then there is the risk of bed-blocking, as also indicated earlier (Gaughanet et. al. 2015). If

long-term care is not available, there is also the risk of higher pressure on civil society, including other family members; this is included in the analysis only to a limited extent, even though it might influence not only well-being, but also the attachment to the labour market of, especially, people with elderly parents.

Rehabilitation, welfare technology and localism

Rehabilitation and re-enablement

Rehabilitation and re-enablement, as well as the use of welfare technology, have for some time been on the agenda in Denmark and other Scandinavian countries. The positive impact of improved physical function has been known for a long-time (Beswick et. al. 2009). This has all been seen in the context of a focus on a more preventative approach. Overall, it can be interpreted also as a way of trying to make use of social innovation in the delivery of services (Sirovatka and Greve 2014). Naturally, an issue is whether the use of technology, while possibly being able to improve quality of life and enable a "good" ageing, might also reduce the option of keeping or developing social relations (Aceros et. al. 2015). Intervention such as re-enablement can also be seen as supporting the independence of the elderly (Aspinal et. al. 2016).

At the institutional level, this can be witnessed by the Law on Social Service §83a, which came into force on 1 January 2015, based upon a political agreement on the future of home care in the Danish Parliament in 2014. It has the intention and obligation for local municipalities to try to rehabilitate in such a way that each elderly person is able to take care of him/herself. This is because the expectation is that the rehabilitation is able to reduce or even eliminate the need for support. If this is not the case, then the elderly shall continue to have the care provided by the local municipality.

The development was based upon evaluation showing the positive impact for workers, users and the local economy. It started with one municipality testing the rehabilitation approach starting in 2009. A report evaluated the rehabilitative efforts in a municipality in Denmark, which has since given its name to the model for rehabilitation in Denmark (e.g. Fredericia-model). This is done by, for example, instead of physically washing up the dishes, helping the elderly to find a way to do the washing up, or to train or give physiotherapy thereby enabling the elderly to do functions which have been lost due to ageing or sickness. The report on this experiment estimated that rehabilitation reduced the cost per service user by 13.9%. Of those participating (408 patients) in the first years: 45% needed no help after the intervention, 40% needed less help and 15% needed the same as in the ordinary home help care (Kjellberg 2011). Recently, there has been evaluation of other approaches to rehabilitation (Kjelberg and Ibsen 2016; Sundhedsstyrelsen, 2017). Rehabilitation became obligatory based upon these evaluations.

In the same law, §79 obliges municipalities for those elderly above the age of 80 to make preventative home visits. It is not obligatory for the elderly to accept these visits, and the municipalities do not need to do so for those in homes for the elderly. There can be variation in the age group at which this service starts, and how often it is done; however, the frequency is at least once a year. In those homes where the elderly person already gets home-help, it is optional for municipalities to offer this service. Municipalities have also been obliged from 2016 to provide this service for those aged 65–79 at risk of having reduced functional

abilities. Lastly, § 112 gives the municipalities possibilities for supporting with help-remedies, including changes in private homes, in order to make it possible for an individual to stay longer in his/her own home.

Introducing welfare technologies

Recent years have also seen a strong increase in different kinds and uses of welfare technology. A recent overview presented by the municipalities organization (KL) was entitled, "Welfare technology has become commonplace in the municipalities" (http://www.kl.dk/Momentum/momentum2017-5-1-id220510/, accessed 15 March 2017). Overall, municipalities are, thus, implementing welfare technology in most places where it is expected to yield a positive outcome for the elderly, the long-term care workers – and also for the economy in the local municipalities. The focus on welfare technology has also been promoted by the state as the municipalities are expected to be able to reduce overall spending on LTC by investing in welfare technology as part of the central economic agreement. So, welfare technology as part of LTC has now become a core issue, including the use of vacuum-cleaners, hoists in ceilings, automatic door-locks and online types of training. Thus, technology for the individual, but also for the staff working in care-homes for the elderly.

Naturally, there are challenges not related to the economic impact of using welfare technology. This revolves around: alienation, conflicting goals, confidentiality and privacy, guaranteeing equal access (Hofmann 2013), while also pointing to the fact that welfare technology "can rehabilitate and enhance people's autonomy" (ibidem, 397). For some, the use of welfare technology is also causing the risk of increased loneliness as it means that fewer persons come to the home of the individual person, and thereby also the possible preventative aspect of being able to know when there is a need for support reduced. It might be argued here that the preventative home-visits as mentioned above can reduce this risk. Alienation refers to the fact that not every elderly person is used to new technologies, but on the other hand many are by now and are expected to be so to a greater extent in the future.

Privacy and confidentiality refer to the fact that new technology might be able to monitor what is actually happening in private homes. As yet, however, there have, seemingly, not been any cases. So, still, the ability to use new technology to support rehabilitation and thereby make it possible for the individual to live an independent life, seems the strongest impact, but still there is a need to research whether possible negative aspects can be related to the use of new technology.

The use of new technology can vary across municipalities – as can the level of services; however, so far, there is no clear and strong knowledge on the degree of differences.

The fact that there might be economic savings, albeit not always in the first year, can also be seen in studies on welfare technology. For example, a business case shows that the payback period for an investment is low for door-automation (3 years), curtain-automation (3 years), hoists in the ceiling (2 years), different toilets (1–3 years dependent on how many functions), whereas it takes 11 years to reach the break-even point for a robot cleaner (Andersen et. al. 2016). Given the speed at which technology develops, these payback periods might be even shorter in the years to come.

Overall, therefore, this points to the fact that decision-makers have included activities that can be considered to have a focus on prevention and understood in a social investment perspective. This is expected to increase the quality of life for the elderly, and also reduce the possible economic pressure on the cost of long-term care due to the increase in the number of elderly people.

The active ageing approach (e.g. the aim to live longer in better health) has also been seen as reducing the pressure on the local municipalities' budgets, and thus prevention in areas other than LTC might reduce the future cost of LTC, albeit budgets for these activities are not counted within the LTC system. Whether it reduces overall public sector spending in total or postpones it to a later age is a further complication if one wants to measure the total impact of these initiatives.

The impact on the frail elderly and their caregivers

As indicated above, there are also possible ethical issues related to the use of welfare technology. The same applies in principle to rehabilitation and re-enablement. A central problem is that, seemingly, many elderly people are lonely. A study by the interest organization Ældresagen revealed that 4% of the elderly aged between 70 and 79, and 6% aged between 80 and 89 are lonely (Ældresagen 2016). Those living alone often have poor health and less well-being than those who do not feel lonely.

This is problematic as loneliness implies a lower level of well-being, and it might have an impact for health care treatment, so there might be a positive trade-off between ensuring a reduction in the level of loneliness and the cost of health care. Reduction in loneliness might, among other issues, be achieved if the elderly person is better able to be active, and thus rehabilitation is part of this; also, for some, using new technology, such as Skype, to make contact with other people. Support to participate in activities where there are other persons can also be an aspect in reducing loneliness.

Another issue relates to the way in which needs for the elderly take into consideration what a spouse/partner can do. The implication being that this might have consequences for the carer's social connections, and also "carers' family identities are also changed as they are confronted with rethinking their roles of spouse, child or sibling" (Keating and Eales 2017, 166), based upon a review of 66 articles dealing with the role of carers. There do not seem to be any Danish studies included, but there is no reason to presume that it will be different in Denmark. Thus, an aspect to consider in deciding the size of long-term care is how this might influence the carer's position. It is the case that more than 40% of people in Denmark provide informal care (because of long-term physical ill health or disability, or problems related to old age), so it does not affect only the elderly (Verbakel et. al. 2017). Therefore, even if this includes people other than the elderly, it points to the fact that there is a pressure on delivering long-term care, and that if informal care decreases, then the elderly might be at risk of a lack of care also in a more universal welfare state, such as Denmark. Also, those providing informal care often might have lower well-being, and thereby they might reduce the amount of informal care they provide.

A study has showed that of those providing long-term care for a spouse or relative, 29% have said no to promotion or work, 9% have reduced theri working hours, 21% have lost income, 15% have reported themselves sick, and 5% have left the labour market earlier than they would otherwise have done (Danmarks Statistik and ÆldreSagen 2015). At the same time, many of those providing care have needed to take over other tasks from the relative, such as paying bills, cleaning, cooking, transport, etc. (Danmarks

Statistik and Ældresagen 2016). A recent survey also indicates that many relatives providing care do it due to the fact that they find public care too limited (albeit a similar number disagree with the viewpoints), and most who provide care work find that it is natural to do so (Voxmeter and Ældresagen 2017).

So, on the one hand, the use of rehabilitation, re-enablement and new welfare technology implies new and better options for many elderly people. They are able, to a greater degree than before, to continue a life close to what they have been living previously They are able to still be active and continue social activities more or less in the same way as previously, which is what many elderly people prefer.

However, at the same time, there is a risk for the very old, especially, that they to a larger degree will be lonely; also, as families with relatively low fertility will have fewer family members, the risk is that their friends will have died before them, and they will be more lonely.

Another risk is that even if there is some rehabilitation for some, this will still not make it possible for them to take care of their daily life, causing a higher care-burden for a spouse/partner or relative (children), thus having a negative impact on their well-being if public long-term care is reduced. As well-being is often not included in the evaluation of the cost of (or lack of) care, then a low level of long-term care can, even in a universal and highly developed welfare state, cause a lower level of well-being for part of the population.

The risk of localism

Another issue in the Danish welfare state is that service for the elderly is delivered by the local municipalities (of which there are 98). They can, within an overall frame (as mentioned earlier), decide the level of long-term care for the elderly. They have the right (again within limits) to decide on local income taxation, and there are also state block grants to help finance the local level of welfare services. However, the municipalities not only have long-term care, they also have as central issues day care for children, primary education and partly active labour market policies, so there is local competition on which activities to support and how to support different activities. The strength is that it might be possible to make decision locally on how best to balance the level of local taxes and the level of services. The weakness is the possible consequence that there is a difference in the level of service available for the elderly dependent on in which municipality they are living. Thus the level of service is different so that, for example, in some municipalities help for cleaning is only provided every third week, while in others it is within one or two weeks.

Therefore, referring to the fourth central question of this article, there is no equality in access as there will be a higher level in some municipalities than in others. People with a higher income might also be better able to buy extra support (such as cleaning, transport, etc.), so that despite universality and a low level of user charges (mainly for medicine and a few other things), there is a relatively low level of service in some municipalities. Thus in order to be able to take care of everyday life, some will be better able to have a higher level of service if they can afford to buy extra.

Recent years have seen a tendency towards marketization in the care for the elderly (Meaghe and Szebehely 2013; Greve 2017). This has mainly taken place within the area of cleaning and other types of practical support in private homes where the elderly by the rules related to free-choice have been allowed

to and always have the option to choose between a private provider and the service from the municipalities. Many elderly people have chosen a private provider – the highest level was in 2014 at 37%, which reduced to 34.1% in 2016. This can be due to two different elements. One being that rehabilitation is taken care of by the public sector, as private providers do not have an incentive to reduce elderly people's need of care as this will reduce the demand for their service. Secondly, there have been many cases of private providers (especially those providing cleaning) who have offered the service for such a low price that the companies have gone bankrupt. The data indicates a break with the development towards marketization in the care for the elderly in the Danish welfare state. At the same time, personal care and homes for the elderly are mainly a public issue within the Danish welfare state – thus still being a service welfare state in this regard.

Conclusion

Denmark has a universal and, in many ways, well-functioning long-term care system. The development towards the use of rehabilitation and welfare technology is important for the lives of many elderly, making it possible to continue in their own life, as is the aim of the Danish long-term care policy. Recent years have shown an increase in the use of rehabilitation, which might be a reason for the decline in spending within the field. Welfare technology has also come onto the agenda in many municipalities, both as a support for the elderly, and also in relation to better working conditions for social care workers.

However, at the same time, there is a risk that some elderly are lonely, and therefore informal care is still very important. The implication is that some people who deliver informal care will have to leave the labour market, bringing with it the risk that their well-being is greatly reduced.

Therefore, even if the use of new methods and approaches is important, and even if seen as social investment in long-term care, one needs to try to include the possible negative impact on the well-being of the elderly caused by the use of these new approaches. How to balance loneliness with the economic gains of rehabilitation and welfare technology is, naturally, at the end of the day, an issue for policy makers when trying to balance different demands and expectations for welfare state delivery. However, without being aware of the risk of loneliness and the impact on well-being for some people, there is a risk that this will be overlooked in the prioritization of the welfare states.

Denmark has reduced spending on long-term care, but also increased the focus on rehabilitation and welfare technology. This can influence loneliness for some, but also opens the way for new options for others. The balance between these issues seems to be a central aspect of the Danish welfare state's development within long-term care in the years to come.

An issue is still also the possible difference in service between different municipalities, which can be both due to different local preferences, and also to different economic options.

[i] I acknowledge support from SPRINT Project which has received funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No 649565.

[ii] See https://statswiki.unece.org/display/AAI.